# Patient Consent Form

Form can also be accessed online at
www.albireoassist.com

**Return completed form by fax: 866-853-0479**
**or email: help@albireoassist.com**

## HIPAA Authorization for Uses and Disclosures of Protected Health Information and Consent for Enrollment

1. **Authorization of Uses and Disclosures.** I hereby authorize and direct (1) all of the health care providers and pharmacies involved in my care and treatment, as well as their employees, office staff, and agents including affiliated health care practitioners (collectively "Providers"), and (2) health care plans and insurers (collectively "Insurers") to use and disclose my "protected health information" ("Information"), as described below, to Albireo Pharma, Inc. and its agents and contractors (collectively, "Albireo"). I also expressly authorize all the uses and disclosures described herein where the Information is provided to Albireo by me.
2. **Description of Information.** I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information and supporting records, including information about my health condition and treatment, and financial information (including information about my insurance) as well as other personal information collected by Providers and/or Insurers about me or otherwise provided by me to Albireo.

   I understand that my pharmacy, health insurers, and third-party vendors may receive remuneration (payment) from Albireo Pharma Inc. in exchange for disclosing my Personal Information to Albireo Pharma Inc. and/or for providing me with support services for the purposes described above.
3. **Purposes.** I authorize and direct Providers and/or Insurers to use and disclose my Information to Albireo for the following purposes:
   a. Operating and administrating medication access programs, including, but not limited to Albireo Assist;
   b. Coordination of prescription fulfillment through pharmacies;
   c. Medication adherence and compliance programs;
   d. Soliciting my participation in patient outreach and advocacy programs; and/or
   e. Other purposes related to patient care and access or similar activities.
4. **Communication.** By signing below, I authorize the use of my Information for Albireo to contact me about my prescription and related activities outlined in Section 3.
5. **Expiration.** Unless revoked, this Authorization will remain in effect for 3 years (or such sooner date as state law may require).
6. **Revocation.** I understand that I have the right to revoke this Authorization by requesting this in writing to Albireo at 53 State St. (Attn: Patient Support), Boston, MA 02109, however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

# HIPAA Authorization for Uses and Disclosures of Protected Health Information and Consent for Enrollment (continued)

7. **Treatment not Conditioned; Signing is Voluntary.** I understand that Providers, Insurers, and/or Albireo will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization. However, if I choose not to sign, Albireo will not be able to help me with the various access programs and other activities outlined above in Section 3.
8. **Potential for Redisclosure.** I understand that Information disclosed pursuant to this Authorization may be redisclosed by Albireo and may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal privacy law.
9. **Copy.** I understand that I will be provided with a copy of this signed Authorization by Albireo, upon request.

We are collecting your personal information for the purposes described above. Please see Ipsen's US privacy policy at https://www.ipsen.com/us/privacy-policy/. Residents of certain states have additional rights regarding the collection, use, and disclosure of their personal information. For more information, please see Ipsen's Supplemental State Privacy Notice at https://www.ipsen.com/us/Supplement-Website-Privacy-Notice/. US residents who are unable to review or access this notice due to a disability may call 844-975-1739 to access this notice in an alternative format.

| **Patient First Name** *(please print)* | **Patient Last Name** *(please print)* | **Patient Date of Birth** *(please print)* |
|---|---|---|
| | | |

## Patient Authorization *(Please complete both sections)*

❑ If I check this box, I also authorize the use of my Information for Albireo marketing activities and consent to receive marketing and promotional communications from Albireo, including information about opportunities to participate in market research. **Checking this box is not a requirement of receiving Albireo medicine or Albireo Assist services.**

**By signing below I am consenting to the use of my Protected Health Information as described above.**

| Patient/Parent or Guardian Name *(if patient under 18 years of age)* *(please print)* | Additional Parent or Guardian Name *(if patient under 18 years of age)* *(please print)* |
|---|---|
| Signature of Patient<br>Patient/Parent/Guardian/Personal Representative Signature Date | Signature of Parent/Guardian<br>Additional Parent/Guardian/Personal Representative Signature Date |
| Description of Relationship to Patient | Description of Relationship to Patient |

**By signing below I am enrolling in Albireo Assist.**

I hereby give consent to Albireo, its agents, and contractors to send communications to me via the contact information I have provided to Albireo, including postal address, email address, and telephone number (for purposes of voice calls and/or SMS text messages).* I understand that this consent will be in effect until I cancel such request. I understand Albireo will not sell the information related to my enrollment in Albireo Assist and will use it only in accordance with this authorization and consent. I have been notified of the privacy policy available at www.albireoassist.com/privacy-policy.pdf I hereby certify that I have read the foregoing and fully understand the contents.

| Patient/Parent or Guardian Name *(if patient under 18 years of age)* *(please print)* | Additional Parent or Guardian Name *(if patient under 18 years of age)* *(please print)* |
|---|---|
| Signature of Patient<br>Patient/Parent/Guardian/Personal Representative Signature Date | Signature of Parent/Guardian<br>Additional Parent/Guardian/Personal Representative Signature Date |
| Description of Relationship to Patient | Description of Relationship to Patient |

*Text messages and voice calls may use automatic telephone dialing systems. Carrier's standard rates may apply. Albireo will not pay these fees. Reply "STOP" to stop receiving texts from Albireo or call 855-ALBIREO.

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